

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9523

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G248 9-21-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

10635

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Barber</b> Last <b>Barber</b>		4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1888</b> <b>Feb. 10, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saw Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mike Barber</b>		14. MOTHER'S MAIDEN NAME <b>SALLY HOPEWELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mary C. Barber Callaway, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>Generalized arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arterio-sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 9</b> , 19 <b>59</b> , to <b>Aug 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 26</b> , 19 <b>59</b> , and that death occurred at <b>9 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Maryland</b> DATE SIGNED <b>SEP 16 '59</b>			
ACTUAL SIGNATURE <b>W. Clarke Mattingley</b> M.D.		DATE SIGNED <b>SEP 16 '59</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>SEP 16 '59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>		22d. LOCATION (City, town, or county) (State) <b>Great Mills, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 16 '59</b>	
ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9524

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09497

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clyde</b> Middle <b>Joseph</b> Last <b>Barnes</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mary Barnes - Great Mills, Md.</b>	
16. SOCIAL SECURITY NO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 446X DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic nephritis</b> (c) <b>Chronic nephritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 18</b> , 19 <b>58</b> , to <b>Aug 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 31</b> , 19 <b>59</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Md.</b> DATE SIGNED <b>8/3/59</b>			
ACTUAL SIGNATURE <b>P.J. Bean</b> M.D.		22. NAME OF CEMETERY OR CREMATORY <b>Holy Face Cem.</b>	
PHYSICIAN'S NAME (Type) <b>P.J. Bean, MD</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Great Mills, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 14 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

CERTIFICATE OF DEATH

2534

NAME OF DECEASED J. Edgar Hoover		SEX Male		RACE White	
DATE OF BIRTH Jan 22, 1895		PLACE OF BIRTH Washington, D.C.		RESIDENCE Washington, D.C.	
DATE OF DEATH Jan 22, 1963		PLACE OF DEATH Washington, D.C.		CAUSE OF DEATH Myocardial Infarction	
TIME OF DEATH 11:00 AM		PLACE OF DEATH Washington, D.C.		CAUSE OF DEATH Myocardial Infarction	
NAME OF DECEASED J. Edgar Hoover		SEX Male		RACE White	
DATE OF BIRTH Jan 22, 1895		PLACE OF BIRTH Washington, D.C.		RESIDENCE Washington, D.C.	
DATE OF DEATH Jan 22, 1963		PLACE OF DEATH Washington, D.C.		CAUSE OF DEATH Myocardial Infarction	
TIME OF DEATH 11:00 AM		PLACE OF DEATH Washington, D.C.		CAUSE OF DEATH Myocardial Infarction	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9525

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 6248 9-9-59 et

Reg. Dist. No.

09498

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mouth of Potomac River</b> c. LENGTH OF STAY IN 1b (area) <b>6 Mos</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b> d. STREET ADDRESS <b>Town Creek Manor</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Kenneth Stanley BOCK</b>			4. DATE OF DEATH <b>August 26 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-5-1929</b>	9. AGE (In years last birthday) <b>29 yrs.</b>	IF UNDER 1 YEAR <b>Months Days Hours Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aviator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>	
13. FATHER'S NAME <b>Stanley Kenneth Bock</b>			14. MOTHER'S MAIDEN NAME <b>Anna Turek</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>Yes 6-49 / 8-59</b>			16. SOCIAL SECURITY NO. <b>611-24-1258</b>		
17. INFORMANT <b>Official U.S. Navy Records, USNAS, Patuxent River, Maryland</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>860X DROWNING</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>IMMED</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jet Aircraft Crash</b>		
20c. TIME OF INJURY <b>1630 o. m. Aug 26 1959</b>		20d. INJURY OCCURRED <b>While at work</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mouth Potomac River, Town Creek Manor, Md</b>		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
W. S. WRAY, CAPT MC USN, THE MEDICAL OFFICER, USNAS PAXRIVERMD					
ACTUAL SIGNATURE <b>Wm. D. BOYD, MD</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>8-30-59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/8/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>	
22d. LOCATION (City, town, or county) <b>Newton</b>		(State) <b>Kansas</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Moody's Funeral Home</b>			24a. REC'D BY REGISTRAR <b>DATE SEP 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>





1  
FOR STATE  
HEALTH DEPT.

9526

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09499

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Mary's City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>	
c. LENGTH OF STAY IN lb <b>1 day</b>		d. STREET ADDRESS <b>1838 Vermont Ave., N. W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's River</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Maurice E. Bryant</b>	4. DATE OF DEATH <b>August 2, 1959</b>	5. SEX <b>Male</b> 6. COLOR OR RACE <b>colored</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>July 27, 1913</b> 9. AGE (In years last birthday) <b>46 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Bryant</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Lecha M. Cawthorne</b>	
17. INFORMANT <b>Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>850X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>over loaded boat, over turned</b> (c) <b>St. Mary's River</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>over loaded boat, over turned</b>	
20c. TIME OF INJURY Month, Day, Year <b>7.15 p.m. 8.2. 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>St. Mary's River</b>	
20f. (City or town) <b>St. Mary's City</b>		(County) <b>St. Mary's</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 6, 1959</b>	
EXAMINER'S NAME (Type) <b>William D. Boyd, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines</b>		24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>	
ADDRESS <b>3001 - 12th St. N.E. Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rhines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in payment within 72 hours after death.





9527

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09500

Reg. Dist. No.

1 X  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington .D.C.</u> <u>47X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Mary's City</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington .D.C.</u> <u>47X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's River</u>			d. STREET ADDRESS <u>4921 Jay Street, N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lorenzo</u> Middle <u>M.</u> Last <u>Carney</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2.</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1924</u>	9. AGE (in years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Carney</u>		
14. MOTHER'S MAIDEN NAME <u>Margie Gray</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		
16. SOCIAL SECURITY NO. <u>  </u>			17. INFORMANT <u>Sophia Wright 80 New York Ave N. W. Washington,</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>over loaded boat, over turned</u>			
20c. TIME OF INJURY Month, Day, Year <u>7.15</u> <u>8.2.</u> <u>1959</u> Hour <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St. Mary's River</u>	20f. (City or town) <u>St. Mary's City, St. Mary's</u>	(County) <u>Md.</u>	(State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William D. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>August 6, 1959</u>	
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8.10.59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington, National</u>	22d. LOCATION (City, town, or county) <u>Arlington,</u>	(State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maquire Funeral Home Washington.D.C.</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD STATE  
DEPT OF HEALTH

0557

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
John Doe		Male		45		10/15/1968		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
123 Main St, Baltimore, MD		Teacher		Myocardial Infarction		Natural		Catholic Cemetery	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		RELIGION	
01/01/1923		Maryland		High School		Married		Catholic	
FATHER'S NAME		MOTHER'S NAME		DATE OF MARRIAGE		NAME OF WITNESS		NAME OF WITNESS	
John Doe		Jane Doe		01/01/1945		John Doe		Jane Doe	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER	
10/15/1968		10:00 AM		Home		[Signature]		Medical Examiner	
DATE OF REPORT		TIME OF REPORT		PLACE OF REPORT		SIGNATURE OF REPORTER		TITLE OF REPORTER	
10/15/1968		10:00 AM		Home		[Signature]		Medical Examiner	



10/15/1968

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9528 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09501

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <span style="float:right">MARYLAND</span>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington, D. C.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Mary's City</u>		c. LENGTH OF STAY IN 1b <u>47x-3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's River</u>			d. STREET ADDRESS <u>4921 Jay Street N. E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>B.</u> Last <u>Carney</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1925</u>	9. AGE (In years last birthday) <u>34 34rs.</u>	IF UNDER 1 YEAR Months <u>34</u> Days <u>34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willie Wright</u>			14. MOTHER'S MAIDEN NAME <u>Sophia Wright</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Sophia Wright 80 New York Ave. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>850x</u>            DUE TO <u>Drowning</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immd.</u>            DUE TO (c) <u>over loaded boat, over turned</u> </div> <div style="width: 35%;">           PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Washington, D.C.</u>            (b) <u>Immd.</u>            (c) <u>Immd.</u> </div> </div>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>over loaded boat, over turned</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7.15</u> p. m. <u>8.2.</u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St. Mary's river</u>	20f. (City or town) <u>St. Mary's City</u>	(County) <u>St. Mary's Md</u>	(State) <u>St. Mary's Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William D. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>August 6, 1959</u>	
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8.10.59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maquire Funeral Home Washington, D.C.</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9529

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09502

1. PLACE OF DEATH o. COUNTY <u>St Marys</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>St Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u>		c. LENGTH OF STAY IN 1b <u>Apr. 15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Richard Estep</u>		4. DATE OF DEATH Month Day Year <u>Aug 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 27, 1922</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mick Estep</u>		14. MOTHER'S MAIDEN NAME <u>Virgie McKee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Ruth Estep, Mechanicsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. failure</u> 592 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Chronic Glomerular Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David L. Mossman</u> M.D.		ADDRESS (Street, city or town, state) <u>Mechanicsville Md</u> DATE SIGNED <u>Aug 16 1959</u>	
PHYSICIAN'S NAME (Type) <u>DAVID L MOSSMAN</u>		<u>MECHANICSVILLE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Morganza Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Wallop, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>AUG 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>	







9530

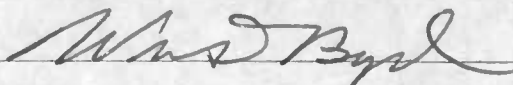
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09503

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Mary's City</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's River</b>			d. STREET ADDRESS <b>2315 Hartford Street S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Thelmo</b> Middle <b>W.</b> Last <b>Francis</b>			4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1926</b>		9. AGE (in years last birthday) <b>33</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Procurement clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Kedex Wiley</b>			14. MOTHER'S MAIDEN NAME <b>Odeasa Wheeler</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Charles E. Francis JR.</b>		17. INFORMANT Address <b>2315 Hartford St. S.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 850 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>overloaded boat, over turned</b>			
20c. TIME OF INJURY Month, Day, Year <b>7.15</b> Hour <b>30</b> p. m. <b>8.2.</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>St. Mary's River</b>	
		20f. (City or town) <b>St. Mary's City, St. Mary's</b>		(County) (State) <b>MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>August 6, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
				22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maquire Funeral Home Washington, D.C.</b>			24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

9531

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09504

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>California</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>California</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 9 months.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>California</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Carol</u> <u>Jackson</u>		4. DATE OF DEATH Month Day Year <u>August</u> <u>6</u> <u>19 59</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1939</u>		9. AGE (in years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leonardtown, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Willard Edmond Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Madeline Wise</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-38-7211</u>		17. INFORMANT <u>Willard E. Jackson</u> Address <u>California, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemothorax ( Massive)</u> <u>822x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>822x</u> DUE TO (c) <u>822x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto over turned &amp; rolled over deceased</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>Auto over turned &amp; rolled over deceased</u>		20c. TIME OF INJURY Month, Day, Year <u>3.30</u> <u>PM</u> <u>Aug. 6, 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 235</u>		20f. (City or town) (County) (State) <u>California</u> <u>St. Mary's</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <u>William D. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>August 6, 1959</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Joy Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Hollywood, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtown, Maryland</u>		24a. REC'D BY REGISTRAR <u>August 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Thomas</u>													

3281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF DEATH  
PLACE OF DEATH  
CITY  
COUNTY  
STATE  
MARRIAGE  
EDUCATION  
OCCUPATION  
RELIGION  
MILITARY SERVICE  
PREVIOUS ILLNESS  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF EXAMINER  
DATE  
PLACE OF EXAMINATION  
CITY  
COUNTY  
STATE

TO BE COMPLETED BY THE EXAMINER

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9532

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09505

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Geo. Island</b>		c. LENGTH OF STAY IN 1b <b>4 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood</b>		d. STREET ADDRESS <b>Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>A.</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-1884</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hammett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>J. Calvin Kerby - Hollywood, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic hypertrophic arthritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> , to <b>Aug 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 21</b> , 19 <b>59</b> , and that death occurred at <b>9:15</b> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Md.</b> DATE SIGNED <b>8/22/59</b>			
ACTUAL SIGNATURE <b>P.J. Bean</b>		M.D. <b>Great Mills, Md.</b>	
PHYSICIAN'S NAME (Type) <b>P.J. Bean, MD</b>		<b>Great Mills, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hollywood Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			







9533

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hollywood</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Doris</b> Middle <b>Marie</b> Last <b>Joy</b>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 9, 1959</b>	
9. AGE (In years lost birthday) yrs. <b>7</b>		IF UNDER 1 YEAR Months <b>7</b>		IF UNDER 24 HRS. Days <b>7</b> Hours <b>7</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Jackson Joy</b>				14. MOTHER'S MAIDEN NAME <b>Mabel Baublitz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT <b>Mother</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>7545</b> IMMEDIATE CAUSE (a) <b>Congenital heart and gastrointestinal disease</b> DUE TO (b) <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>1:59</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-9</b> , 19 <b>59</b> to <b>8-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/14/59</b> , and that death occurred at <b>7:30 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Joseph E. Gill</b>				ADDRESS (Street, city or town, state) <b>Leonardtwn Md.</b> DATE SIGNED <b>8/19/59</b>			
PHYSICIAN'S NAME (Type) <b>Joseph E. Gill M.D.</b>				Leonardtwn, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 20 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

2078339XV5

CERTIFICATE OF DEATH

9233

1

9534

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09507

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Louis Mattingly</u>			4. DATE OF DEATH Month Day Year <u>August 21, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1913</u> <u>March 8, 1913</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hollywood, Maryland</u>
13. FATHER'S NAME <u>James H. Mattingly</u>			14. MOTHER'S MAIDEN NAME <u>Clara Mae Wallace</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-5016</u>	17. INFORMANT <u>Mildred M. Mattingly</u> Address <u>Leonardtwn, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William D. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/21/59</u>	
EXAMINER'S NAME (Type) <u>William D. Boyd M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>	22d. LOCATION (City, town, or county) <u>Leonardtwn, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
M  
C  
078  
I  
0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: Prior to this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9535

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09508

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James W</u> Middle <u>Moreland</u> Last <u>Moreland</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1959</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W Moreland</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Elizabeth Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>multiple congenital anomalies</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 3</u> , 19 <u>59</u> , to <u>Aug 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 3</u> , 19 <u>59</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Leon W Berube</u> M.D.		PHYSICIAN'S NAME (Type) <u>Leon W Berube M.D.</u> <u>Mechanicsville</u> <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-5-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>	22d. LOCATION (City, town, or county) (State) <u>Morganza</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Evans</u> DATE <u>AUG 5 '59</u>	

2078231XV5

one single continental snowflake  
is a perfect masterpiece

from the  
pen of  
a  
poet



9536

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09509

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				d. STREET ADDRESS <b>Maddox</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>Edgar</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 27, 1895</b>		9. AGE (In years last birthday) yrs. <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maddox, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>G. U. Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Julia Ann Goode</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W W I</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Lessie G. Thompson Maddox, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Wernia</b> DUE TO (c) <b>Acute myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 days</b> <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 28, 1949</b> , to <b>August 26, 1959</b> , that I last saw the deceased alive on <b>August 26, 1959</b> , and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Leonardtwn, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>Robert F. Fuchs</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert Fuchs M.D.</b> <b>Leonardtwn, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>		22d. LOCATION (City, town, or county) (State) <b>Chaptico, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: Prior to this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Blank form with horizontal lines for text entry.

FOR STATE  
HEALTH DEPT

9537

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09510

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> <b>COUNTY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maddox</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>			d. STREET ADDRESS <b>806 - 54 th St. N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>OBDIAH</b> First <b>WHITE</b> Middle <b>-----</b> Last <b>WHITE</b>			4. DATE OF DEATH <b>August 3, 1959</b> Month <b>August</b> Day <b>3</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/1933</b>	9. AGE (In years last birthday) <b>26</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>James White</b>		
14. MOTHER'S MAIDEN NAME <b>Willie Dixon</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW2</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs. Willie White</b> Address <b>5212- B St. S.E. Wash. D.C.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>injured</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased jumped over board to save a friend</b>			
20c. TIME OF INJURY Month, Day, Year <b>4:30 p.m. Aug 3 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wicomico Riv. Maddox</b>	20f. (City or town) <b>St Marys Md</b>	20g. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Wm. D. Boyd, MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/5/59</b>	
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-7-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington, National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rollins Funeral Home</b>		ADDRESS <b>4339 Hunt Pl. N.E. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 14 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



9538

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09511

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>47x3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maddox</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>339-54th St. N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wicomico River</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Wright</u> Middle <u>Wright</u> Last		4. DATE OF DEATH Month <u>Aug.</u> Day <u>3</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-23-1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baggage handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mail</u>	11. BIRTHPLACE (State or foreign country) <u>Georgetown, South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Wright</u>	
14. MOTHER'S MAIDEN NAME <u>Cecilia Gray</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>249-16-6384</u>		17. INFORMANT <u>Luciella Wright Hemingway, South Carolina</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Imme</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Intoxicated, jumped overboard, could not swim.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4.30</u> Hour <u>30</u> p.m. <u>8.3.</u> 19 <u>59</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wicomico River</u>	20f. (City or town) (County) (State) <u>Maddox St. Mary's Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm D Boyd</u>		DATE SIGNED <u>August 6, 1959</u>	
EXAMINER'S NAME (Type) <u>William D. Boyd, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Williams Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines</u>		24a. REC'D BY REGISTRAR <u>3001 - 12th. St. N.E. Washington, D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>AUG 11 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: WILLIAM J. BROWN

2. Sex: Male

3. Age: 45

4. Date of birth: 1910-10-15

5. Place of birth: NEW YORK

6. Usual residence: 1234 E. BALTIMORE ST. BALTIMORE, MD.

7. Cause of death: Myocardial infarction

8. Date of death: 1955-11-10

9. Time of death: 10:15 AM

10. Place of death: Home

11. Signature of medical examiner: [Signature]

12. Signature of physician: [Signature]

13. Signature of coroner: [Signature]

14. Signature of registrar: [Signature]

15. Signature of undertaker: [Signature]

16. Signature of funeral home: [Signature]

17. Signature of cemetery: [Signature]

18. Signature of other: [Signature]

19. Signature of other: [Signature]

20. Signature of other: [Signature]

21. Signature of other: [Signature]

22. Signature of other: [Signature]

23. Signature of other: [Signature]

24. Signature of other: [Signature]

25. Signature of other: [Signature]

26. Signature of other: [Signature]

27. Signature of other: [Signature]

28. Signature of other: [Signature]

29. Signature of other: [Signature]

30. Signature of other: [Signature]

31. Signature of other: [Signature]

32. Signature of other: [Signature]

33. Signature of other: [Signature]

34. Signature of other: [Signature]

35. Signature of other: [Signature]

36. Signature of other: [Signature]

37. Signature of other: [Signature]

38. Signature of other: [Signature]

39. Signature of other: [Signature]

40. Signature of other: [Signature]

41. Signature of other: [Signature]

42. Signature of other: [Signature]

43. Signature of other: [Signature]

44. Signature of other: [Signature]

45. Signature of other: [Signature]

46. Signature of other: [Signature]

47. Signature of other: [Signature]

48. Signature of other: [Signature]

49. Signature of other: [Signature]

50. Signature of other: [Signature]

51. Signature of other: [Signature]

52. Signature of other: [Signature]

53. Signature of other: [Signature]

54. Signature of other: [Signature]

55. Signature of other: [Signature]

56. Signature of other: [Signature]

57. Signature of other: [Signature]

58. Signature of other: [Signature]

59. Signature of other: [Signature]

60. Signature of other: [Signature]

61. Signature of other: [Signature]

62. Signature of other: [Signature]

63. Signature of other: [Signature]

64. Signature of other: [Signature]

65. Signature of other: [Signature]

66. Signature of other: [Signature]

67. Signature of other: [Signature]

68. Signature of other: [Signature]

69. Signature of other: [Signature]

70. Signature of other: [Signature]

71. Signature of other: [Signature]

72. Signature of other: [Signature]

73. Signature of other: [Signature]

74. Signature of other: [Signature]

75. Signature of other: [Signature]

76. Signature of other: [Signature]

77. Signature of other: [Signature]

78. Signature of other: [Signature]

79. Signature of other: [Signature]

80. Signature of other: [Signature]

81. Signature of other: [Signature]

82. Signature of other: [Signature]

83. Signature of other: [Signature]

84. Signature of other: [Signature]

85. Signature of other: [Signature]

86. Signature of other: [Signature]

87. Signature of other: [Signature]

88. Signature of other: [Signature]

89. Signature of other: [Signature]

90. Signature of other: [Signature]

91. Signature of other: [Signature]

92. Signature of other: [Signature]

93. Signature of other: [Signature]

94. Signature of other: [Signature]

95. Signature of other: [Signature]

96. Signature of other: [Signature]

97. Signature of other: [Signature]

98. Signature of other: [Signature]

99. Signature of other: [Signature]

100. Signature of other: [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 5/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9539

CERTIFICATE OF DEATH

09512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avenue</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>KECK</b> Last <b>E. Young</b>				4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25, 1900</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Jones</b>				14. MOTHER'S MAIDEN NAME <b>Mary Mills</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs Rosetta Jones</b>				Address <b>3404 13th ST. N.W. Apt. 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Acute cardiac decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Arterio sclerotic cv disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> to <b>Aug 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 18</b> , 19 <b>59</b> , and that death occurred at <b>1 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ray E. Fisher</b>				DATE SIGNED <b>Mechanicsville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>MECHANICSVILLE, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>				ADDRESS <b>MECHANICSVILLE, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

1733

1733

1733

1733

1733

1733

1733

1733

1733

1733

1733

1733

1733

1733